Harm Reduction Drug Policy

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Congressman Souder, distinguished members of the Congress. It is my position and that of the Institute on Global Drug Policy that the most effective drug policy is a restrictive policy based on primary prevention, abstinence-focused rehabilitation, and strong law enforcement. All three of these fill important functions if drug policy is to succeed.

At one time, the concept of "Harm Reduction" seemed to be a reasonable approach to decrease the effect that drug abuse would have on society. However, the phraseology and policies termed "Harm Reduction" have been hijacked by those who are seeking to tear down drug policy and ultimately gain decriminalization or legalization of drugs. These catch phrases are parroted by the leaders of the movement like Ethan Nadelman, or Arnold Trebach who contend that the harms from drug use are exceeded by the harms of trying to control it. Pat O'Hare, former director of the International Harm Reduction Society, has said, "If kids can't have fun with drugs when they are young when can they?" In some venues, Harm Reduction has been a ruse to cover criminal behavior with a cloak of political advocacy and cynical care for addicts.

The Harm Reduction movement has gained much of its international push from groups that also support drug legalization such as the Drug Policy Alliance, the Marijuana Policy Project, Open Society Institute, and dozens of spin off organizations who seek to hide destructive and illegal behavior under the shroud of political advocacy.

Billionaire George Soros, along with a cadre of other wealthy individuals such as Peter Lewis, John Sperling, George Zimmer, has financed these organizations along with numerous Harm Reduction and legalization schemes. His nucleus of power brokers are attempting to destabilize drug policy as we know it. If you have heard the phrase "the drug war has failed," chances are the message is being brought to you via such people. Saying, "The Drug War has failed," flies in the face of substantial and steady reductions in drug use since the 1970's. For instance, among high school students marijuana use has dropped by about half since the 1970's. It is an attempt to demoralize the public and destroy the gains of restrictive drug policy. If any other medical malady had dropped by that amount, we would celebrate in the streets.

Harm Reduction policy has become a cynical process for marginalizing and giving up on the addict while contending that drug use is inevitable. It also completely ignores the huge group of non-addicted users which serves to recruit non-users into drug using behavior, and which serves as a large reservoir to provide future addicts.

Examples of its misguided components include:

Drug prevention focused on teaching "responsible" and inevitable drug use

Needle handouts (needle exchange programs, NEP's)

Non-abstinence based treatment such as heroin hand-out programs

Responsible crack cocaine use kits

"Safe" shooting rooms for IV drug addicts

Drug decriminalization or legalization.

Medical excuse marijuana.

Time does not allow me to discuss each of these issues in depth, but I have provided publications which discuss these topics. I will cover some highlights.

Needle handouts to IV drug abusers are a great farce. There should be at least three measures of success for needle handouts: 1) Is there a consistent reduction in Hepatitis B, C and HIV in terms of net incidence and conversion rate among the participants not just on the needles tested? 2) Is there a significant reduction in actual use of IV drugs and a consistent increase in the numbers of patients who originate in NEPs who end up seeking and participating in treatment? 3) Is there an elimination of dirty needles on the street? You will find that most, if not all, needle handouts fail in every one of these measures.

Detailed evaluations in Montreal and Seattle as well as several others clearly demonstrate that HIV and Hepatitis B and C among the participants in needle handouts increases over non-participants. In Montreal, a study of HIV seroconversion rate found a rate of 7.9 per 100 person-years among NEP participants, and a rate of 3.1 per 100 person-years among non-participants. A cumulative probability of 33% HIV seroconversion existed among NEP participants as compared to 13% for non-users.

An analysis of behaviors in needle handouts in Puerto Rico demonstrated no significant change in injection habits; only 9.4% entered treatment, but results improved in the last month of the study by aggressive outreach. At the low, only 12.4% and at the high only 40.3% of needles were returned, and 26.6% of the needles turned in were sero positive for HIV.

In Seattle, in 1996 prevalence of HIV, Hepatitis B, and Hepatitis C were respectively 1%, 8%, and 17%. In February 2002, prevalence was 2%, 18%, and 66%. The conclusion was that the needle exchange program alone was not able to control the spread of Hepatitis C.

I refer to NEPs as needle handouts because even among the best programs in North America, 38 % of the needles are not returned. In 1998 that amounted to over 7 million needles floating around on our streets. On average , a singe heroin user will require around 2,900 needle per year, and a cocaine user as many as 7,300. The cost and health exposure of giving needles to the approximately 3 million addicts would be staggering. Of course, once a needle is used, it becomes contaminated and must be disposed of safely. For example, the NEP in Sidney Australia handed out 262,000 needles in 2003, and in the area of the NEP program, so many children were stuck with dirty needles that parents have quit reporting it.

A comparison between the prevention strategies of Norway, Sweden, and Denmark demonstrated that HIV counseling and testing may be more effective than needle handouts alone. Sweden and Norway had significantly lower rates of HIV in IV users as compared to Denmark where needles were the primary approach but with lower levels of counseling and required participation than Sweden. HIV rates in Denmark (with needle handouts) have been found since 1991 to be 1.49/1000, in Norway they were 0.92/1000 in 1991—0.58 in1996, in Sweden 0.77/1000 in1991 and 0.58/1000 in 1996

It is essential to remember that NEPs do nothing for the underlying drug addiction, and they waste precious resources that could be devoted to outreach, intervention, and treatment. No one has demonstrated that the outcomes for HIV control are superior to aggressive intervention and treatment.

The notion of “responsible” drug use among children is one of the most sinister components of harm reduction. It upholds the misguided notion that kids can be taught to use drugs responsibly. A key leader in this movement, Marsha Rosenbaum, promotes a concept called “Safety First.” Recently, they have endorsed a book called, “It’s Just a Plant.” This is a pre-teen book teaching small children to accept marijuana. Credits in the book thank none other than George Soros. I include passages from the book that glorify marijuana and seek to create a positive picture on the part of children. At one place in the book, the little girl is gleefully telling her mother that she wants to grow her own marijuana plants. Once children are seduced into the marijuana culture, they may not escape it.

Those who embrace "responsible" drug use appear willing to ignore the fact that judgment is one of the first areas of impairment with drug use. While that creates its own set of problems in adults, it is even worse in young people who have not yet developed social and wise decision-making skills. The idea of teaching kids responsible marijuana use, much less heroin, cocaine, or methamphetamine use, is ludicrous.

So-called safe shooting galleries give addicts supposedly protected locations to take their drugs, and again, do nothing for the underlying destructive disease of addiction. Some cities have tried things like safe-crack kits teaching addicts to smoke crack instead of injecting and to not share pipes without cleaning them completely ignoring the destructive consequences of the continued drug use.

The medical excuse marijuana movement is a dramatic example of how millions of dollars can purchase drug policy and public opinion. In the papers I have included on marijuana, I document examples of the millions of dollars spent to manipulate various state marijuana initiatives. Soros and associates are jeopardizing consumer protection and have created an environment of medicine by popular vote rather than by science. None of the multiple international scientific evaluations have considered smoking crude pot to be an adequate medical treatment. I would be happy to discuss this in detail if requested.

Drastic examples of failed Harm Reduction policy include Vancouver, Baltimore, Holland, and Switzerland.

In Vancouver, despite a needle handout which gave out over 3 million needles in 2000, prevalence rates of HIV were 35% for men and 25.8% for women and was largely linked to cocaine use. Studies have demonstrated that 27.6% of participants in the Vancouver needle handout reported sharing needles in prior 6 months and needle sharing remains an alarmingly common practice. In the NEP, 50% of recipients who were also on methadone treatment still share needles. Vancouver also spends $3 million per year on "safe" injections sites whose staff claim to have treated "only" 107 overdoses so far.

As if their situation is not bad enough, health officials in Vancouver, Montreal, and Toronto have recently announced that the cities will experiment with giving addicts daily doses of heroin. From 1994 to 2004 use of marijuana has doubled. Thirty percent of young people in Canada age 15 to 17 have used marijuana in the last year. Such an approach to drug use is having other dire consequences. Concurrent with the extremely lax attitude toward drug use, British

Columbia has the highest number of drug overdose deaths per capita (4.7 per 100,000) which is the leading cause of death in adults age 30-49.

The Harm Reduction philosophy in Baltimore was initiated under Mayor Kurt Schmoke. Since the inception of Harm Reduction, the heroin use in Balitmore has become a staggering problem and is reputed as one of the worse in the USA. Its violent crime rate per 100,000 population equals or exceeds that of Detroit, New York City, San Diego, Dallas, San Francisco, Denver, Los Angeles, Miami, or Atlanta. The purity of the heroin used there is extremely high, and there is an influx of young people coming into the city to obtain heroin because of the relatively lax enforcement attitude and sense of protection of users.

The 2002 DAWN (Drug Abuse Warning Network) Data demonstrates that the drug related fatality rate reported in the Baltimore was 23 per 100,000 population. Heroin was the cause of 69% of these deaths. This drug-related mortality rate is about twice as high as Chicago, Dallas, Denver, New York, and about 35% higher than Philadelphia. Harm reduction has clearly failed in Baltimore.

Those controlling Swiss drug policy have been at odds with many traditional Swiss physicians who favor abstinence and rehabilitation for addicts. The Swiss heroin hand out program that was initiated several years ago was condemned by the World Health Organization as being so poorly designed and monitored that no conclusions could be derived. There was no mandatory examination of HIV rates, patients self reported use rather than being verified by drug testing, there existed no independent evaluation of criminal behavior, and even minimal employment was counted as employment. Furthermore, addicts within the trial were more likely to have access to essential social services than those outside of the heroin handout which gave them a greater chance of appearing productive in the study.

Holland has been the poster child of Harm Reduction policies especially as it relates to marijuana. While marijuana use has not been frankly legalized, the general atmosphere of acceptance has created numerous social problems. Numerous marijuana-selling coffee shops have emerged which provide marijuana. From 1990 to 1995, youth marijuana consumption increased by 142%. The number of organized crime groups rose from 3 to over 90. From 1997 to 2001 lifetime marijuana use increased 32%, cocaine use increased 121%, and methamphetamine increased 52%. Holland is now the leading exporter of the drug ecstasy (MDMA). As expected, HIV rates have risen 45% from 2001-2002.

The lax policy in Holland has resulted in a vexing problem of "drug tourism" involving mostly young people coming into the country specifically to use drugs or to purchase and take them. Ironically, tighter controls have been imposed to try to curb this substantial problem.

The bigger question when there is any consideration of drug policy changes is who will be the winners and who will be the losers. The winners will be clear. As we have also learned from the tobacco and alcohol industries, those who would step up to distribute and sell marijuana, or other illegal drugs, those who could profit from a futures or investment market, and those who want to continue using the drugs would profit to the detriment of the rest of us. Tough questions should be asked of the supporters of such changes.

Kids, families, and drug users themselves will be the losers with any policy that embraces decriminalization or legalization of drugs as an element. That, in turn, threatens the very viability of our nation.

In summary, a Harm Reduction policy is essentially a harm production policy. Hopefully Congress will ignore those who contend that current drug policy has failed, and will continue to support restrictive drug policy which embraces harm prevention through primary prevention, and harm elimination through treatment and enforcement efforts. Our goal should be no use of illegal drugs and no illegal or unhealthy use of legal drugs.